

# Advice to medical practitioners about the use of postmenopausal hormone therapy: A statement issued by the RANZCOG on 13 August 2004

*The purpose of this statement is to provide evidence-based advice for the medical community regarding hormone therapy (HT, otherwise called HRT or hormone replacement therapy). In this statement, HT covers the use of estrogen alone and estrogen plus progestin (progestogen) for the use of women around midlife.*

HT is effective and may be used for:

- the management of some menopausal symptoms such as hot flushes, night sweats and sleep disturbance;
- the treatment of vaginal atrophy and associated sexual problems; and
- the prevention of fragility (osteoporotic) fractures as an option when first line therapies are not available or are contraindicated.

For otherwise healthy women with moderate to severe symptoms, the benefits of short term HT are likely to outweigh the risks.

## **DISEASE PREVENTION AND POSSIBLE RISKS OF HT**

The focus of this statement has been on using the best quality data available. In most instances, these have been from the Women's Health Initiative (WHI) study conducted in the USA. It should be noted that the participants in these chronic disease prevention studies were generally older than women conventionally treated for menopausal symptoms, and hence their risks for adverse events were generally higher. These studies were not designed to address the short term risks and benefits of hormones given for the treatment of menopausal symptoms.

Disease risk estimates are given for Australian women around the age of 50 years. The possible changes in risk are provided directly from the WHI study of women aged 50 to 79 years. Data are not available for the possible effects of

HT in Australian women, or for women specifically in the early postmenopausal years. Thus, the figures from WHI provide the best available estimates of change in the broad age group studied. It cannot be assumed that the same risk estimates apply to subgroups, for example, women aged 50 to 59.

## **CORONARY HEART DISEASE**

Coronary heart disease in healthy low risk women within the first ten years of natural menopause is uncommon. The incidence of hospitalisation for the diagnosis of coronary heart disease for women, aged 45 to 54 years, is approximately 39 cases per 10,000 per year (Australian Institute of Health and Welfare National Hospital Morbidity Database).

There is insufficient evidence regarding the effects of HT on coronary heart disease in the early post-menopausal years.

A risk increase in the order of approximately seven extra events per 10,000 women per year was seen in the WHI study for US women aged 50 to 79 years.

HT should not be initiated for the prevention or treatment of coronary heart disease.

## **VENOUS THROMBOEMBOLIC EVENTS**

In healthy women with no risk factors for venous thromboembolic events (VTE), the risk increases substantially with age.

The absolute baseline risk for women aged in their fifties is one in 10,000 per year, increasing to 100 per 10,000 per year for women aged in their eighties. The use of oral HT is associated with an approximate doubling of this risk.

Women at high risk of VTE should be individually assessed if HT is being considered.

## **STROKE**

Stroke is uncommon in women in the first decade after natural menopause, with the approximate incidence rate for women aged 45 to 54 years, based on a population study, being between seven and eight strokes per 10,000 women per year. In women aged 55 to 64, this increases to 26 per 10,000 per year.

In the Women's Health Initiative study, the use of HT by women aged between 50 and 79 years was associated with an increase in risk of stroke of approximately eight to 12 events per 10,000 women per year.

## **COGNITION AND DEMENTIA**

Studies of HT on cognitive function do not show consistent effects.

There is insufficient evidence at this time to support an increase or decrease in the risk of dementia with the use of HT in women over the age of 65. HT should not be used for the prevention or treatment of dementia.

## OSTEOPOROSIS AND FRACTURE

HT reduces the risk of spine, hip and other fragility fracture. In asymptomatic post-menopausal women at risk, HT may be an option for reducing fracture risk when first line options are not available or are contraindicated. Information on the therapies for the prevention of fragility (osteoporotic) fracture can be found in:

Seeman E, Eisman JA. Treatment of osteoporosis: why, whom, when and how to treat. The single most important consideration is the individual's absolute risk of fracture. *MJA* 2004; 180:298-303.

## BREAST CANCER

The risk of invasive breast cancer for women aged 50 to 59 years is approximately 27 per 10,000 women per year.

The use of combined estrogen-progestin therapy in WHI was associated with an increase in risk for women aged 50 to 79 years of approximately eight extra cases per 10,000 women per year.

Increased risk is associated with duration of exposure (in WHI, the increase in breast cancer became evident after four years of use).

The only major randomised trial of estrogen-only therapy in hysterectomised women (WHI) showed no increase in risk of invasive breast cancer after 6.8 years.

There is no evidence that these effects will differ between doses, mode of

administration or type of estrogen or progestin.

## OVARIAN CANCER

Some studies have suggested a possible increase in ovarian cancer with HT. However, there is insufficient evidence from high quality studies to draw conclusions regarding the effects of HT on ovarian cancer. The age standardised incidence of ovarian cancer in Australia for women, aged between 50 and 59 years, was one to two cases per 10,000 women per year.

## ENDOMETRIAL CANCER

Endometrial cancer is diagnosed in approximately four to five women per 10,000, aged 50 to 59, per year in Australia. There is no increased incidence with continuous combined HT. However, there is a well documented increase in risk associated with estrogen-only therapy in women with an intact uterus.

## COLORECTAL CANCER

Some studies have suggested a possible decrease in colorectal cancer with HT. However, there is insufficient evidence from high quality studies to draw conclusions regarding the effects of HT on colorectal cancer. Colorectal cancer is diagnosed in about six to seven women per 10,000, aged 50 to 59 per year in Australia.

## SPECIAL CONSIDERATIONS

### Duration of therapy

As the risk benefit ratio will change with time, all women should be reviewed at least annually. Notwithstanding the lack of quality evidence, the lowest effective dose should be prescribed. Some women may require long-term therapy for symptom control.

### Early menopause

There is no available evidence regarding the risks and benefits of long-term use of HT in women who undergo an early menopause. Based on expert opinion, women who have undergone an early menopause are usually advised to use HT until they reach the age of natural menopause.

### Bio-identical hormones

These products are not registered as medicines. There is no evidence either for or against the safety and efficacy of hormonal products described as 'bio-identical' or compounded hormones.

### Complementary therapies

No evidence-based statement can be made about the benefits or risks of any of these therapies.

All post-menopausal women for whom HT use is being considered should be fully informed of their potential individual benefits and risks.

For a comprehensive review of the literature, visit the NHMRC website: <http://www.health.gov.au/nhmrc/publications/synopses/wh34syn.htm>

## AOCOG 2005, Seoul, Korea

The 19th Asian and Oceanic Congress of Obstetrics and Gynaecology will be hosted from 1 to 5 October 2005 in Seoul, Korea. The meeting is being hosted by the Korean Society of Obstetrics and Gynaecology under the auspices of the Asia and Oceania Federation of Obstetrics and Gynaecology (AFOG). The theme of the meeting is *Creating a new value of women's health in the 21st century*.

The topic areas of the scientific program will cover gynaecological oncology, gynaecological endocrinology, maternal-fetal medicine, urogynaecology and general gynaecology.

The deadline for abstract submission is 31 March 2005. For further details about on-line registration and abstract submission, visit the AOCOG website at [www.aocog2005.org](http://www.aocog2005.org)